

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SUBSTANCE ABUSE ATTACHMENT (PA/SAA)**

Providers may submit prior authorization (PA) requests and attachments by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Substance Abuse Attachment (PA/SAA) Completion Instructions (HCF 11032A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Performing Provider

5. Performing Provider's Medicaid Provider Number (not required)

6. Telephone Number — Performing Provider

7. Name — Referring / Prescribing Provider

8. Referring / Prescribing Provider's Medicaid Provider Number

SECTION III — TYPE OF TREATMENT REQUESTED

9.

☐ Primary Intensive Outpatient Treatment

- ☐ Individual ☐ Group ☐ Family
- Number of minutes per session _____ Individual _____ Group _____ Family
- Sessions will be ☐ Twice / month ☐ Once / month ☐ Once / week ☐ Other (specify) _____
- Requesting _____ hours per week, for _____ weeks
- Anticipating beginning treatment date _____
- Estimated intensive treatment termination date _____
- Attach a copy of treatment design, which includes the following:
 - a) Schedule of treatment (day, time of day, length of session, and service to be provided during that time).
 - b) Description of aftercare / follow-up component.

☐ Aftercare / Follow-Up Service

- ☐ Individual ☐ Group ☐ Family
- Number of minutes per session _____ Individual _____ Group _____ Family
- Sessions will be ☐ Twice / month ☐ Once / month ☐ Once / week ☐ Other (specify) _____
- Requesting _____ hours per week, for _____ weeks
- Estimated discharge date from this component of care _____

Continued

SECTION III — TYPE OF TREATMENT REQUESTED (Continued)

☐ Affected Family Member / Codependency Treatment

- ☐ Individual ☐ Group ☐ Family
- Number of minutes per session _____ Individual _____ Group _____ Family
- Sessions will be ☐ Twice / month ☐ Once / month ☐ Once / week ☐ Other (specify) _____
- Requesting _____ hours per week, for _____ weeks
- Anticipating beginning treatment date _____
- Estimated affected family member / codependency treatment termination date _____
- Attach a copy of treatment design, which includes the following:
 - a) Schedule of treatment (day, time of day, length of session, and service to be provided during that time)
 - b) Description of aftercare / follow-up component

SECTION IV — DOCUMENTATION

10. Was the recipient in primary substance abuse treatment in the last 12 months? ☐ Yes ☐ No ☐ Unknown

If "yes," provide dates, problem(s), outcome, and provider of service.

11. Enter the dates of diagnostic evaluation(s) or medical examination(s).

12. Specify diagnostic procedures employed.

Continued

SECTION IV — DOCUMENTATION (Continued)

13. Provide current primary and secondary diagnosis (refer to the current Diagnostic and Statistical Manual of Mental Disorders) codes and descriptions.

14. Describe the recipient's current clinical problems and relevant history. Include substance abuse history.

15. Describe the recipient's family situation. Include how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

16. Provide a detailed description of treatment objectives and goals.

Continued

SECTION IV — DOCUMENTATION (Continued)

17. Describe expected outcome of treatment (include use of self-help groups if appropriate).

SECTION V — SIGNATURES

I have read the attached request for PA of substance abuse services and agree that it will be sent to Wisconsin Medicaid for review.

18. SIGNATURE — Recipient or Representative (optional)	19. Date Signed
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20. Relationship (if representative)

Attach a photocopy of the physician's prescription for treatment. The prescription must be signed and dated within three months of receipt by Wisconsin Medicaid (initial request) or within 12 months of receipt by Wisconsin Medicaid (subsequent request). (Physician providers need not attach a prescription unless treatment is prescribed by another physician).

21. SIGNATURE — Performing Provider	22. Date Signed
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23. Discipline of Performing Provider	24. Performing Provider's Medicaid Provider Number
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25. SIGNATURE — Supervising Provider	26. Date Signed
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